STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154050	A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN CENTER	1850 WESLEY RD AUBURN, IN46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A0000	The visit was for a Federal hospital recertification survey. Facility Number: 003734 Survey Date: 06-15-11 to 06-16-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 07/08/11	A0000		
A0166	The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. Based on policy and procedure review, patient medical record review, and interview, the facility failed to implement its policy related to updating the treatment plan for patients after an ESI (emergency safety intervention), for 3 of 3 restrained/secluded patients (pts. N5, N6	A0166	All nursing staff will receive training in the requirements related to updating and modifying patient's plan of care accordingly to hospital policy and regulations set forth in 482.13 (3) (4) (i). All policies will reflect the same updated need of information, specifically related to seclusion	08/19/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and N7). Findings: 1. At 4:40 PM on 6/16/11, review of the policy RM1140, "Seclusion, Restraint, and Emergency Intervention Procedures - Inpatient", indicated: a. in the section "Procedure: Emergency Intervention", in item 1.9 (on page 6), it read: "All episodes of Emergency Interventions will be reviewed by the treatment team and revisions made to the treatment plan as appropriate to minimize the need for using Emergency Interventions to protect the patient or others." 2. Review of patient medical records at 10:45 AM on 6/16/11 indicated: a. on 5/18/10, pt. N5 was placed in the seclusion room at 2100 hours, after a physician order was given b. pt. N5 lacked any update to the treatment plan after the 5/18/10 seclusion event c. at 0758 hours on 1/6/11, pt. N6 was placed in a physical restraint while a chemical restraint was administered d. the treatment plan for pt. N6 was not updated after the ESI of 1/6/11 e. on 1/21/11 at 0720 hours, pt. N6 was placed in a physical restraint while a chemical restraint was administered f. the treatment plan for pt. N7 was not		and restraints. More specifically, treatment plans will have a column or a reflection showing updated where modification to treatment has been made. Training will take place in a nursing meeting / inservice and via email to all nursing staff with a post test for verification of understanding. We will monitor this through addition of a column in our daily audit that reflects a modification was identified and changed. Person Responsible: Hospital Director and ADON (Risk Management Nurse) and supervisor over auditors.	

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	updated after the ESI of 1/21/11 3. Interview with staff members NA and NB at 3:40 PM on 6/16/11 indicated: a. additions or changes to the treatment plans after ESIs for pts. N5, N6 and N7 could not be found b. it cannot be determined that updates to the treatment plans is occurring per policy requirements, after the implementation of emergency safety interventions			
A0168	The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. Based on policy and procedure review, patient medical record review, and interview, the facility failed to implement its policy related to physician orders for restraint or seclusion for 1 of 3 patients who were restrained/secluded (pt. N7). Findings: 1. At 4:40 PM on 6/16/11, review of the policy RM1140, "Seclusion, Restraint, and Emergency Intervention Procedures - Inpatient", indicated: a. on page 3 in the "Procedure: Restraint or Seclusion for Behavior	A0168	The provider will educate all nursing staff related to 482.12 (c) related to policy and procedures relating to physician orders for restraint and seclusion and the timeliness of such orders. Staff training will include the understanding that the use of restraint and seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under this regulation and authorized to order restraint or seclusion by hospital policy in accordance with State law. Training will take place in a	08/19/2011

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	Management" area, in section 2.0 "RN Assesses for Patient Safety...2.2.3 Notifies the physician *immediately* of the need to restrain or seclude and obtains an order..." 2. Review of patient medical records at 10:45 AM on 6/16/11 indicated: a. pt. N7 had a form titled "Original Order to Restrain/Seclude" with a date of 1/21/11 and time of 0720 hours, that lacks: I. the name of the ordering practitioner II. any authentication by a practitioner of the order to restrain pt. N7 b. pt. N7: I. had nursing notes of 1/22/11, on the "Nurse's Progress Notes" page, at 1900 hours that read: "[writer] was called to 300 side by other staff to help with pt. Deputy [named] with other staff were alongside pt. who was on [their] stomach laying on the floor...pt. was agitated and shouting then attempted to roll over from [their] stomach to [their] side.." II. lacked a physician order to restrain pt. N7, notify local authorities and remove the patient from the facility 3. Interview with staff member NB at 3:00 PM on 6/16/11 indicated : a. the nurse failed to write the name of the ordering practitioner b. there is no physician authentication of		nursing meeting / inservice and via email to all nursing staff with a post test for verification of understanding. Compliance monitoring will take place via daily audit reviewing timlieness of orders. Person Responsible: Hospital Director and ADON (Risk Management Nurse)	

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	the order to restrain pt. N7 on 1/21/11 c. there is no physician order to restrain pt. N7 on 1/22/11 or to notify local police to have the patient removed from the facility			
A0196	Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. Based on policy and procedure review, personnel file review, and interview, the facility failed to ensure the competency related to restraint and seclusion techniques for 1 of 2 LPNs (licensed practical nurses). (staff member P4) Findings: 1. At 4:25 PM on 6/16/11, review of the policy number RM1140, "Seclusion, Restraint, and Emergency Intervention Procedures - Inpatient", indicated: a. in the "Policy Statement" section, it read: "...All direct patient care staff will be trained in patient assessment, recognition, and treatment of the problems causing the need for restraint, seclusion, and emergency intervention. Training...through the use of Non-Abusive	A0196	Staff will be trained in accordance with regulation 482.13 (f) (1) relating to patient rights on restraint and seclusion. Restraint and seclusion techniques will be on orientation, demonstrated technique before performance of actions specified under this regulation and in accordance with policy and subsequently periodic interval checks according to policy, NAPPI. This training will be conducted by the hospital NAPPI trainer who is the ADON (Risk Managment Nurse) and periodic checks will be conducted by the Director for compliance. Training will take place in a nursing meeting / inservice and via email to all nursing staff with a post test for verification of understanding. Responsible Party: Inpatint Director and ADON	07/15/2011

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	Psychological and Physical Intervention (NAPPI) training,..." 2. Review of the personnel file for P4, a LPN, at 4:15 PM on 6/15/11, indicated the competency in NAPPI (Non-Abusive Psychological and Physical Intervention) had expired in February of 2011 3. Interview with staff members NB and ND at 5:05 PM on 6/15/11 indicated the NAPPI competency for staff member P5 was required to fulfill their duties as a LPN, and that their competency had expired in February of this year		(Risk Management)	
A0206	[The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. Based on personnel file review and interview, the facility failed to ensure CPR (cardiopulmonary resuscitation) competency for 1 of 3 RNs (registered nurses). (staff member P5) Findings: 1. At 4:15 PM on 6/15/11, review of personnel files indicated CPR competency for staff member P5, a RN, had expired	A0206	The provider will assure the use of first aid techniques and certification and recertification in the use of CPR will be made compliant for all staff of the hospital to assure patient safety. Periodic reviews will be done to assure this regulation 482.13 (f) (2) (vii) and hospitals policy will be demonstrated. Monthly reviews and notices will be sent to all staff via email and interoffice mail for compliance	08/19/2011

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	3/11 2. Interview with staff members NB and ND at 5:05 PM on 6/15/11 indicated CPR certification for staff member P5 was required per their job expectations, and that certification had expired in March		notification. Responsible Party: Director and Assistant Director (Risk Management Nurse)	
A0267	The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. Based on policy and procedure review, patient medical record review, incident report review, and interview, the quality assurance coordinator failed to ensure the implementation of the facility policy related to completion of an incident report after an emergency situation for one patient (pt. N7) and failed to monitor quality indicators for one service (laboratory) in their Quality Assessment and Performance Improvement program. Findings: 1. At 4:40 PM on 6/16/11, review of the policy RM1140, "Seclusion, Restraint, and Emergency Intervention Procedures - Inpatient", indicated: a. under "Procedure: Emergency Intervention", on page 6 in section 3.0, it reads: "A complete and thorough incident report shall be completed within 24 hours following any incident involving use of	A0267	The hospital will assure that the QAPI Quality Indicators will be measured, analyzed and tracked more effeciently for performance that assess processes of care, hospital services and operations. Two areas that will be monitored and reviewed with a tracking log will be all incident reports will be logged in and followed up through this tracking device to assure return to the Assistant Director of Nursing (Risk Management). The laboratory orders will be tracked for timeliness on the daily Audit which is being done daily by the Administrative Office Staff to assure compliance with 482.21 (a) (2). Responsible Party: Director, Assistant Director of Nursing and, Supervisor of Administrative Assistants).	08/19/2011

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time-limited emergency interventions and forwarded to the Risk Management Nurse..."

2. Review of patient medical records at 10:45 AM on 6/16/11 indicated pt. N7:

a. had nursing notes of 1/22/11, on the "Nurse's Progress Notes" page, at 1900 hours that read: "[writer] was called to 300 side by other staff to help with pt. Deputy [named] with other staff were alongside pt. who was on [their] stomach laying on the floor. The deputy was kneeling over the pt with left knee in [pt's] back and two tazer prongs were stuck on [pt's] upper back. pt. was agitated and shouting then attempted to roll over from [their] stomach to [their] side. Deputy [named] again tazed the pt...Officer [named] joined Deputy [named] towards the tail-end of the incident."

b. had a note written by nursing at 1915 hours that stated: "pt escorted off unit by an [city] policeman et (and) a sheriff's deputy. [pt] was handcuffed and crying. Report called to [other acute care psychiatric hospital]"

3. Review of facility incident reports for the past 12 months indicated there was none present related to the events of 1/22/11 for pt. N7

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	4. Interview with staff members NC at 2:00 PM on 6/16/11 indicated: a. the incident of 1/22/11 for pt. N7 was unknown by this staff member b. there was no incident report completed by staff related to the ESI (emergency safety intervention) event, tazing, and police intervention for pt. N7 on 1/22/11 c. the restraint/tazer event of 1/22/11 for pt. N7 was not reported to the quality assurance/risk management staff person for review by the quality assurance committee 5. The Quality Improvement (QI) report for 2010 lacked performance measurements for the contracted laboratory services provided to the facility. 6. During an interview on 06-16-11 at 1345, employee #A3 confirmed that laboratory services are not evaluated through the QI program.			
A0701	The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.			

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	Based on observation, manufacturer's recommendation, and interview, the facility failed to ensure patient safety related to possible incorrect glucometer results and oximeter results, due to expired products. Findings: 1. Review of the manufacturer's recommendation for glucometer control solutions ("MediSense Glucose Control Solution") at 4:00 PM on 6/16/11 indicated: a. in the section "Storage and Handling", it reads: "...when you open a new bottle, write the date of opening on the bottle label..." b. in the section "Precautions and Warnings", it reads: "Do not use control solutions 90 days after opening or if they are expired..." 2. While on tour of the nursing station, in the company of staff members NB and NF, at 4:00 PM on 6/16/11, it was observed that: a. the control solutions for the glucometer were not dated when opened or when they expire (90 days after opening, as per manufacturer recommendation) b. 4 packages of Oxi max oxygen sensors (to test oxygen saturation levels) had expired 12/10	A0701	All nursing staff will be trained in accordance with 484.41 (a) relating to manufacturer's recommendations relating to glucometer solution controls ("MediSense Glucose Control Solution") for storage and handling, relating to opening of a new bottle and expiration date should not be followed by the bottle date but by the "open" date of control which is 30-days from "Open" date according to manufacturer's recommendations. Training will take place in a nursing meeting / inservice and via email to all nursing staff with a post test for verification of understanding. Compliance will be monitored by daily medication room checklists that will be conducted by third shift.Responsible Party: Director and Assistant Director (Risk Management)	08/19/2011

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	3. Interview with staff members NB and NF at 4:10 PM on 6/16/11 indicated: a. it was unknown that the manufacturer recommended expiration of the control solutions 90 days after opening b. it cannot be determined when the current control solutions were opened, or when the 90 day expiration date is/was c. the oxygen sensors that expired were for a previous machine and should have been purged from the supply area			
A0724	Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. Based on observation and interview, the facility failed to ensure an acceptable level of sanitation was maintained by the housekeeping department at the facility. Findings: 1. During a facility tour on 06-15-11 at 1540, the following was observed in a housekeeping storage area: one gallon containers of a cleaning concentrate Wayne PQ-64. The product labeling failed to indicate it was a hospital grade disinfectant and indicated a dilution ratio of 2 ounces per gallon water used. 2. During an interview on 06-16-11 at	A0724	Accepatable levels of sanitation will be maintained by the housekeeping department in accordance with 482.41 (c) (2). Periodic checks will be conducted by the Infection Control Nurse (ADON) to assure compliance of products dilution ratio and assuring that the disinfectant is hospital grade and labeled as such. Any changes in products to the hospital will be approved prior to change with the Infection Control Nurse (ADON).Training by the Infection control nurse will be conducted periodically.Responsible Party: Director and Infection Control Nurse (ADON).	06/20/2011

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	0935 hours, employee #A6 indicated the product Wayne PQ-64 was used throughout the facility for floor mopping. The employee indicated they were instructed to use one capful of the product diluted with 4.5 gallons water for mopping and indicated they did not use a 1 ounce unit measure pump observed with the stored cleaning products. 3. During an interview on 06-16-11 at 1630, employee #A2 indicated the Infection Control committee had not been consulted prior to the selection and use of the cleaning product by the housekeeping department to ensure a hospital grade disinfectant was selected for use at the facility.			
A0749	The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. Based on policy and procedure review, personnel file review, and interview, the facility failed to ensure an effective program to identify communicable disease history for 5 of 9 staff members (P2, P3, P4, P7 and P9). Findings: 1. At 9:00 AM on 6/16/11, review of policy number FA0448, "Immunization	A0749	The hospital will assure that an infection control system for identifying, reporting and investigating and controlling infections and communicable disease of patients and personnel will be maintained in compliance with 482.42 (a) (1). Periodic checks relating to authentication will be established with Infection Control Nurse and Human Resources verifying	08/19/2011

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	Record - IP" (in patient), indicated: a. under "Summary", it read: "To meet necessary state and federal mandates, all inpatient staff that provides direct care must provide documentation of immunizations for, or antibodies to, MMR (measles, mumps, rubella) and Varicella (Chicken Pox), by having the attached form completed on their behalf, or by submitting a copy of an official State Immunization Form which indicates immunization." b. under "Statement of Information:", it read in section 2.0, "[facility] Inpatient Services employees shall secure evidence from their general practitioner they they have either had the required immunizations, a titer test indicating immunization, have had the inquired about disease, or have secured the official State Immunization form as evidence of immunization." 2. Review of personnel files at 2:55 PM and 4:15 PM on 6/15/11 and 8:15 AM on 6/16/11, indicated: a. P2, P3, P4 and P7 (all hired between January 2008 and November 2010) were lacking documentation related to immunization status for Varicella b. staff members P4 and P7 were lacking documentation of a 3rd Hepatitis B injection (had documentation of #1 and #2 in the series of 3)		authentication of physician or APN signature is on appropriate health history form. Hepatitis B vaccinations will be followed up in the 3 shot interval with notice to employee via email for verification of notice on compliance dates. All documentation will be reviewed by the Infection Control Nurse prior to Human Resource attainment of items to verify immunity and authentication of the appropriate health history form. Responsible Party: Director and Assistant Director (Infection Control Nurse) and Human Resources.	

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	c. P9 had a document/health history form with self reported immunity to measles, mumps, rubella and varicella that was lacking physician authentication of the declaration 3. Interview with staff members NB and ND at 4:50 PM on 6/15/11 and 9:55 AM on 6/16/11, indicated: a. staff members P4 and P7 never presented to the nurse for their last Hepatitis B injection in the series of 3, but there is no documentation in their files of contact made with these staff members and their failure to connect with the nurse/employee health b. it is unclear why varicella immunity documentation for staff members P2, P3, P4 and P7 was not obtained at the time of hire c. human resources failed to ensure that staff member P9 had physician authentication on the appropriate health history form			
A1160	Services must be delivered in accordance with medical staff directives. Based on document review, observation and interview, the facility failed to have policies/procedures for the provision of respiratory therapy ensuring that medications were administered according to accepted standards of practice by the	A1160	Respiratory care services will be implemented into policy and training for all licensed nursing staff. The need for this knowledge will be updated in the Job Description for all nursing staff under "other" responsibilities and	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154050	A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN CENTER	1850 WESLEY RD AUBURN, IN46706

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	nursing staff. Findings: 1. On 06-15-11 at 1030 hours, employee #A1 was requested to provide policies/procedures for respiratory therapy services and none was provided prior to exit. 2. During a facility tour on 06-15-11 at 1210 hours, several aerosol nebulizer pieces were observed drying on a paper towel in the medication room. Employee #A7 indicated the nursing staff administered aerosol treatments to patients and documented on the patient medication administration record. 3. During an interview on 06-15-11 at 1250 hours, employee #A2 indicated nursing staff did not document breath sounds, heart rate, respiratory rate and/or oxygen saturation before and after aerosol treatment administration. 4. During an interview on 06-16-11 at 1610, employee #A1 confirmed the facility lacked policies/procedures for aerosol nebulizer administration to patients by licensed nursing staff.		skill and will be included in the nursing notes when a respiratory treatment is given, i.e. heart rate, respiratory rate, and oxygen saturation levels before and after treatments (aerosol) administration. Policies and training will reflect the change in accordance with 482.57 (b). Training will take place in a nursing meeting / inservice and via email to all nursing staff with a post test for verification of understanding. Compliance will be conducted through our daily audits by a third party on anyone who receives respiratory specific treatment. Responsible Party: Director and ADON (Risk Management Nurse)	